STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155757	A. BUILDING 00 B. WING	03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEGATE VILLAGE	7510 ROSEGATE DR INDIANAPOLIS, IN 46237

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F0000	This visit was for the Investigation of Complaints IN00104048 and IN00104412. Complaint IN00104048 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F223, F282, F309 and F425. Complaint IN00104412 - Unsubstantiated. Allegation did not occur. Unrelated deficiency cited Survey dates: March 15, 23 & 26, 2012 Facility Number: 011149 Provider Number: 155757 Aim Number: 200829340 Survey Team: Mary Jane G. Fischer RN Census Bed Type: SNF: 34	F0000	Please accept this 2567 Plan of Correction for the Complaint Survey ending March 26, 2012 as the Provider's Letter of Credible Allegation. This Provider respectfully requests a Post Survey Revisit on or after April 16, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 106 Total: 140 Census Payor Type: Medicare: 43 Medicaid: 78 Other: 19 Total: 140 Sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/29/12 by Suzanne Williams, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure a resident's physician was immediately notified, in that when	F0157	F- 157 – Notify of Changes **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/16/2012

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	a resident had breathing difficulties and displayed increased edema, the nursing staff failed to act immediately and inform the resident's physician for intervention related to a decline in the resident's condition, for 1 of 3 residents reviewed with specific physician orders in a sample of 6. [Resident "B"]. Findings include: The record for Resident "B" was reviewed on 03-15-12 at 11:30 a.m. Diagnoses included but were not limited to acute renal failure, peritonitis, hematuria, asthma, cirrhosis and hepatic encephalopathy. These diagnoses remained current at the time of the record review. The record indicated the resident had recently been discharged from a local area hospital on 12-05-11 and returned to the facility with instructions for the nursing staff to "Contact information: MD for		**practice?** · Resident "B" was discharged from the facility on 2/20/12. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents having changes in condition have been identified. Physician(s) have been notified and residents have been placed on "hot charting" (change of condition) until condition(s) are stable and/or resolved. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Charge nurse who identifies the change in condition will contact the resident's physician to communicate the change. · Charge nurse will document all nursing actions/interventions in the nurse's notes and will add the resident to the "Hot Charting" list 7 days a week and each shift. · DNS and/or designee will ensure daily, to assure documentation of the changes in condition and appropriate follow-up has been addressed and physician has been notified. · Nursing staff will be in-serviced by Director of Nursing and/or designee on April 3, 4, & 5, 2012 on physician notification.	

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	worsening ascites, abdominal pain, confusion or temperature of > [greater] 100.5." In addition, the resident had a physician order for "daily weight, if at or about 5 lbs. [pounds] in 1 week or 3 lbs. in 24 hours call [name of physician]." Review of the resident's current plan of care dated 02-02-12, indicated "Problem cirrhosis." "Approach - approach start date 12-13-11, observe for altered mental status, increased pain, abdominal distention and discomfort, n/v [nausea/vomiting], increased weakness/debility, decreased appetite." A subsequent plan of care dated 02-02-12, indicated "Acute renal failure." "Approach - approach start date 12-13-11, observe for s/s [signs and symptoms] of SOB [shortness of breath], increased edema, pain or elevated B/P [blood pressure], refer to MD [Medical Doctor] as needed."		**How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized to monitor compliance with reporting changes of condition by the Director of Nursing and/or designee. Nurse's notes observations will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance has been achieved. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in development of action plans, staff re-education and/or disciplinary action.	

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	An additional plan of care dated 02-02-12 indicated "Resident is at risk for fluid imbalance related to diuretics and fluid restriction." "Approach - approach start date 12-05-11 - observe for s/s of dehydration/fluid overload: dry pale mucous membranes, skin tenting, decreased urinary output, SOB [shortness of breath], dyspnea, increased edema, lethargy, increased wts. [weights], increased abdominal girth." Review of the nurses notes indicated the following: "02-17-12 at 2245 [10:45 p.m.] HR [heart rate] 92, oxygen saturation 93% on room air, [blood pressure] 138/70, T [temperature] 98.2, RR [respiratory rate] 18. No needs currently, no c/o [complaints of] pain, minor SOB [shortness of breath], no dyspnea [difficulty in breathing]. Pt. [patient] does not desire any intervention at this time, occasional NP [non productive] cough, lungs - [arrow pointing			

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	downward] volume with crackles in bases and rhonchi present bil. [bilateral] expiratory wheezing present. BS [bowel sounds] positive times 4, abdomen does appear slightly distended, but soft. Pt. states had BM yesterday evening (02-16). Pulses equal / reg. [regular] BUE [bilateral upper extremities]." "02-18-12 at 0100 [1:00 a.m.] [B/P] 127/76, P 108, oxygen saturation 90 % on room air, RR 20, T 96.7. Pt c/o SOB, lungs are diminished all lobes with inspiratory / expiratory wheezing present. Pt. c/o pain in back also (5/10). Intervention inhaler 2 puffs, neb. [nebulizer] tx. [treatment] and pain tx. with prn [as needed] Tramadol [a pain medication]. Pre treatment O2 [oxygen] 90%, shallow breathing, post intervention [arrow pointing downward] wheezing, deep breathing and O2 98 %. Pt. A & O [alert and oriented] times three. Pedal pulses palpable bil. [bilateral] with 3 +			

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	pitting edema BLE [bilateral lower extremities]. Pt. tachacardic <sic> with minor murmur present." "02-19-12 at 2:00 p.m. - ... Abd. [abdomen] firm / dist. [distended] LS [lung sounds] slightly exp. [expiratory] wheezes - productive cough with green sputum - MD notified. Res. req. [requested] Pro-air [an inhaler] at 1:45 p.m. for wheezing, + effective, +2 pit. [pitting] edema to BUE [bilateral upper extremities], bruising noted to BUE...." "02-19-12 at 2315 [11:15 p.m.] [BP] 116/67, P 102, T 97.8, O2 93% room air, RR 20. Pt. has c/o SOB also wheezing present at this time. Inspiratory / expiratory, lung sounds diminished throughout. Will treat with Duoneb [inhaler]. Pt. has c/o pain in shoulder. Educated pt. on importance of turning deep breathing and coughing to prevent atelectasis/pneumonia. Abd. [abdomen] distended and BLE			

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	[bilateral lower extremities] pitting edema 3+ - heels elevated d/t [due to] severe abdominal distension putting pressure on diaphragm and lungs. Keeping HOB [head of bed] elevated > [greater than] 30 degrees." "02-20-12 [day shift] BP 115/61, [P] 95, O2 92 % - room air, [respirations] 20. [Arrow pointing upward] 3.4 # [pounds] - called Dr. [Doctor] to report [arrow pointing upward] wt. gain - Dr. wants res. [resident] sent to [name of local area hospital] ER [emergency room] for eval. [evaluation]." From the time the nurse assessed the resident at 11:15 p.m., the physician was not notified of the resident's condition for approximately 6 1/2 hours later, when the day shift nurse weighed the resident and discovered the resident with a 3.4 pound weight gain. Review of the facility policy on			

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	03-23-12 at 10:00 a.m., titled "Resident Change of Condition," and dated as "revised 3/10," indicated the following: "POLICY [bold type] It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely and effective intervention occurs." "PROCEDURE - 2. Acute Medical Change a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician." This Federal tag relates to complaint IN00104048. 3.1-5(a)(3)			

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F0223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure a resident was free from verbal abuse in that when a dependent resident required care, the certified nurses aide verbally abused the resident. In addition, when a cognitively impaired resident displayed physical behavior during care, the Certified Nurses Aides [CNAs] continued to insist the care be completed which only compounded the behaviors displayed by the resident, and then the CNA hit the resident. This deficient practice effected 2 of 3 residents reviewed for abuse in a sample of 6. [Resident "C" and "F"].	F0223	F223- Free from Abuse/ Involuntary Seclusion **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident F was discharged from this facility on 1/21/12. · Resident C resides at the facility and is treated with dignity and respect during CNA care. Employees were in-serviced on Abuse, and The Elder Justice Act and Misappropriation of Property on April 10, 2012, by Facility Administrator. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected and are free of staff to resident abuse. · Residents were assessed	04/16/2012

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	Findings include: 1. The record for Resident ""C" was reviewed on 03-23-12 at 9:45 a.m. Diagnoses included, but were not limited to, rheumatoid arthritis, hypertension, depression anxiety, severely deformed hands/feet/digits with hyper extension and insomnia. These diagnoses remained current at the time of the record review. Review of the 11-08-11 Minimum Data Set assessment indicated the resident had no cognitive impairment or memory loss. A review of facility provided reportable incidents to the ISDH indicated the following: "[Resident] subjected to alleged verbal abuse by CNA [certified nurses aide] employee #13, and indicated the resident was a "pain in the a**." This incident occurred on 08-28-11 between 10:00 p.m. and 6:00 a.m. shift.		and interviewed for feelings of safety, using the QIS questioning tool by the Social Service staff. As a result of this questioning, no resident voiced that they were abused. · Residents with escalating behaviors have been identified with behavior management plans developed and implemented. Care plans for behavior management have been developed and Care tracker has been updated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · CNAs were in-serviced on Dealing with the Combative and Agitated resident by Social Service Staff on 10, 2012. · Nursing will be in-serviced on the Behavior Management program on April 12 and 13, 2012 by Social Service Director. · All Staff in-service on Abuse, and The Elder Justice Act and Misappropriation of Property on April 10 and 12, 2012 by the Facility Administrator. · Continued in-servicing on Abuse by the SDC Quarterly. · Employees are in-serviced on Abuse in Orientation and	

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	During an interview on 03-23-12 at 1:15 p.m. Resident "C" indicated "Oh that was a long time ago. I know she said I was a pain in the a** - I don't know if she still works here or not, but she doesn't take care of me." Further record review of the facility interview with CNA employee #13 indicated the following: "[Name of CNA] verbalized she worked on 08-28-11 from 10:00 p.m. to 6:00 a.m. and [name of resident "C"]. [Name of CNA employee #13] verbalized that during the 1st 5 hours of her shift that [name of resident] was on [call] light every 15 - 20 minutes." The CNA further indicated she went to the resident's room about 10 - 12 times and the resident would ask to have pillows moved, to be pulled up in bed, to fill water pitcher and place on the bedpan. The CNA indicated other staff helped her through the shift and further named the individuals. CNA employee #13 indicated that		periodically during on-going in-service education as needed. · Charge nurse will provide supervision to CNA to observe staff to resident interactions on all shifts, 7 days a week. Any inappropriate interactions will be addressed and documented immediately. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with Abuse Prohibition, Reporting and Investigation. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance is achieved. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in action plans, staff re-education and/or disciplinary action.	

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	"at one point that her and [name of CNA employee #14] were in the resident's room taking [resident] off the bedpan and the resident was complaining that no one will do anything for [resident]. CNA employee #13 verbalized to the resident 'you're being a pain in the a**, but I wouldn't point that out to you.'" The report further indicated the CNA employee #13 "is acting different and is doing this because [resident] wants to be in control." Review of the facility provided interview with the Resident on 08-29-11 indicated the following: "Resident voiced to writer last night 08-28-11 after 10 p.m. staff said she was a 'pain in the a**.' Resident said aide came in room on 3 different occasions last night 08-28-11. The first time resident asked aide for a pillow for elbow because [resident] has a big thing on it, cream for legs and to close curtain. Resident voiced aide did what she asked. Resident voiced she had a miserable night and could			

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	not go to sleep. The second time resident asked aide to place her on bed pain <sic>, which the aide placed on <sic> resident on bed pan. The third time when aide came in she was accompanied by another aide and told her [in reference to the resident] was a 'real pain in the a**.' Resident informed writer, [resident] is not scared but 'it is just the way she talked to me that I did not like. I did not think it was right.'" The facility indicated they placed CNA employee #13 on a performance improvement plan as the CNA "did not promote dignity and self respect to resident when she spoke inappropriately to resident." Review of the employee file for CNA #13 indicated she continued to work at the facility until she resigned on 02-01-12. 2. The record for Resident "F" was reviewed on 03-26-12 at 11:30 a.m.			

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	Diagnoses included, but were not limited to, inflammatory colitis, dementia, dementia with behaviors, and depression. These diagnoses remained current at the time of the record review. The 12-07-11 Minimum Data Set assessment indicated the resident had cognitive impairment with short and long term memory loss. Review of the facility provided information related to an allegation of abuse with this resident and CNA employee #12 indicated the following: "Professional Conclusions - On 01-05-12 at about 7:30 a.m. employee [CNA #15] witnessed [CNA employee #12] 'swat' [name of Resident "F"] on right arm while providing care to the resident who was combative. [Name of CNA employee #15] asked [CNA employee #12] to leave the room but CNA employee #12 refused to do so. [Name of CNA employee			

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	#15] stayed in room until care was completed to ensure resident safety and then immediately reported incident to supervisor." "[Name of CNA employee #12] verbalized that resident was combative and verbally aggressive when she and [name of CNA employee #15] attempted to give shower earlier in the shift. Resident continued to be combative with care and was showing increased restlessness while the CNAs were attempting to get the resident dressed. The nurse attempted to give resident medications but [resident] spit them out. [Name of CNA employee #12] verbalized while providing care the resident had kicked and hit her." "[Name of CNA employee #15] verbalized in her interview that while helping [name of CNA employee #12] transfer resident, [resident] started punching [name of CNA employee #12] in the stomach. While [resident] was			

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	hitting her, [CNA employee #12] 'swat' at residents right arm. [Name of CNA employee #15] asked [name of CNA employee #12] to leave the room and she would finish resident's care, but [name of CNA employee #12] refused to leave the room. So she stayed in room to ensure resident's safety, after she and [name of CNA employee #12] left the room she went and report incident to supervisor. [Name of CNA employee #15] verbalized that she did not feel that [name of CNA employee #12] did this out of abuse but out of frustration. After staff were interviewed we were unable to substantiate if the 'swat' was intentional. Employee reports she had an involuntary response and put her hands up in the air, stating, 'My reflex made it look as if I hit [resident] but I didn't, I put my hands in the air.' Even though the investigation did not substantiate that abuse occurred by [name of CNA employee #12] the employee was termed as she has received			

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	previous care concerns with accompanying disciplinary actions and education." Review of the nurses notes dated 01-05-12 at 8:00 a.m. indicated the following occurrence with the resident. "Resident extremely agitated. Resident kicking, screaming, biting and punching staff members. It took 3 people to shower and dress [resident] because of the combativeness. [Resident] repeatedly tried to scoot out of wheelchair and shower chair also." During interview on 03-26-12 at 2:10 p.m. licensed nurse employee #5 indicated she was involved with the incident with Resident "F" and the CNA's, however indicated she was unaware it took 3 staff members to shower and dress the resident. "They should have backed away." When further interviewed if CNA employee #15 put on the call light for assistance			

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	when she advised CNA employee #12 to leave the room, licensed nurse employee #5 indicated the CNA should have put on the call light and finished the care herself. I didn't hear about it until afterwards." Review of CNA employee #12 file indicated she had been involved in instances of "inappropriate interaction with a resident" on 09-30-08, allegation against employee that "may constitute verbal abuse" on 08-11-09 and eventually terminated on 01-05-12 for "inconsiderate treatment of a resident." 3. Review of the Facility policy on 03-15-12 at 9:15 a.m., titled "Abuse Prohibition, Reporting and Investigation," dated February 2010, indicated the following: "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse,			

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	mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." "DEFINITIONS OF ABUSE - Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish." "Physical abuse [underscored] includes hitting, slapping, pinching, and kicking." "Verbal abuse [underscored] defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident's or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability." This Federal tag relates to complaint IN00104048. 3.1-27(a)(1)			

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	3.1-27(b)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review the facility failed to ensure physician orders and plans of care were followed, in that when a resident had physician orders for medications and assistive devices, the facility failed to ensure the resident received the medications and devices as ordered, and failed to follow the plan of care for 2 of 6 sampled residents. [Residents "B", "E"]. Findings include: 1a. The record for Resident "B" was reviewed on 03-15-12 at 11:30 a.m. Diagnoses included, but were not limited to, acute renal failure, peritonitis, hematuria, asthma, cirrhosis and hepatic encephalopathy. These diagnoses remained current at the time of the record review.	F0282	F- 282-Services by Qualified Persons/Per Care Plan **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident “B” was discharged from the facility on 2/20/12, before the chart was reviewed. · Resident “E” was discharged from the facility on 3/18/12, before the chart was reviewed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents with personal alarm orders have been identified. Resident’s beds and wheelchairs have been audited to ensure alarms are in place in accordance with each resident’s written plan of care and Care tracker updated. · All residents MARs have been reviewed for medications that have been withheld. Residents identified as having medications withheld due to medication unavailable, have had	04/16/2012

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	Review of the resident's current plan of care dated 02-02-12 indicated "problem - asthma." "Approach - approach start date 12-13-11 - administer med's [medications] as ordered." A review of the resident's physician rewrite for February 2012 included an order, dated 12-05-11 for Advair diskus [a bronchodilator] 250/50 - inhale 1 puff every twelve hours. The inhaler was scheduled to be administered at 9:00 a.m. and 9:00 p.m. Review of the February 2012 medication administration record indicated the resident did not receive the inhaler as prescribed at 9:00 a.m. and 9:00 p.m. and February 13th and 14th and again at 9:00 a.m. on February 15th [2012]. The reverse side of the medication administration record indicated the following: "02-13-12 advair 250/50		pharmacy notified and medications have been sent per physician orders. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · An in-service will be completed by the Director of Nursing and/or designee on April 3, 4, & 5, 2012 to licensed nurses regarding facility processes for medication administration and delivery of medications. · The Director of Nursing Services and/or designee will assign a licensed nurse to review the medication and treatment administration records daily to ensure medications have been administered per physician orders. · The Director of Nursing Services and/or designee will conduct personal alarm audits daily to ensure alarms are in place per physician order. Care plan and Care tracker will be updated accordingly. (Care tracker is an electronic CNA assignment sheet) **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with medication administration. Audits will be	

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	unavailable - phar. [pharmacy] notified." "02-13 advair 250/50 unavailable - phar. notified." "02-14 advair 250/50 unavailable." "02-15 advair 250/50 unavailable - phar. notified said sent on 01-23-12 - found bottom drawer at 1:30 p.m." 1b. The record indicated the resident had recently been discharged from a local area hospital on 12-05-11 and returned to the facility with instructions for the nursing staff to "Contact information: MD for worsening ascites, abdominal pain, confusion or temperature of > [greater] 100.5." In addition, the resident had a physician order for "daily weight, if at or about 5 lbs. [pounds] in 1 week or 3 lbs. in 24 hours call [name of physician]." In addition, when the resident had a decline/change of condition, the nursing staff failed to follow the resident's current plan of care for intervention/approaches as follows:		completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance is achieved. · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance of residents with personal alarms. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance is achieved. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in development of action plans, staff re-education and/or disciplinary action.	

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	Review of the resident's current plan of care dated 02-02-12, indicated "Problem cirrhosis." "Approach - approach start date 12-13-11, observe for altered mental status, increased pain, abdominal distention and discomfort, n/v [nausea/vomiting], increased weakness/debility, decreased appetite." A subsequent plan of care dated 02-02-12, indicated "Acute renal failure." "Approach - approach start date 12-13-11, observe for s/s [signs and symptoms] of SOB [shortness of breath], increased edema, pain or elevated B/P [blood pressure], refer to MD [Medical Doctor] as needed." An addition plan of care dated 02-02-12, indicated "Resident is at risk for fluid imbalance related to diuretics and fluid restriction." "Approach - approach start date 12-05-11 - observe for s/s of dehydration/fluid overload: dry			

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	pale mucous membranes, skin tenting, decreased urinary output, SOB [shortness of breath], dyspnea, increased edema, lethargy, increased wts. [weights], increased abdominal girth." Review of the nurses notes indicated the following: "02-17-12 at 2245 [10:45 p.m.] HR [heart rate 92, oxygen saturation 93% on room air, [blood pressure] 138/70, T [temperature] 98.2, RR [respiratory rate] 18. No needs currently, no c/o [complaints of] pain, minor SOB [shortness of breath], no dyspnea [difficulty in breathing]. Pt. [patient] does not desire any intervention at this time, occasional NP [non productive] cough, lungs - [arrow pointing downward] volume with crackles in bases and rhonchi present bil. [bilateral] expiratory wheezing present. BS [bowel sounds] positive times 4, abdomen does appear slightly distended, but soft. Pt. states had BM yesterday			

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	evening (02-16). Pulses equal / reg. [regular] BUE [bilateral upper extremities]." "02-18-12 at 0100 [1:00 a.m.] [B/P] 127/76, P 108, oxygen saturation 90 % on room air, RR 20, T 96.7. Pt c/o SOB, lungs are diminished all lobes with inspiratory / expiratory wheezing present. Pt. c/o pain in back also (5/10). Intervention inhaler 2 puffs, neb. [nebulizer] tx. [treatment] and pain tx. with prn [as needed] Tramadol [a pain medication]. Pre treatment O2 [oxygen 90%, shallow breathing, post intervention [arrow pointing downward] wheezing, deep breathing and O2 98 %. Pt. A & O [alert and oriented] times three. pedal pulses palpable bil. [bilateral] with 3 + pitting edema BLE [bilateral lower extremities]. Pt. tachacardic <sic> with minor murmur present." "02-19-12 at 2:00 p.m. - ... Abd. [abdomen] firm / dist. [distended] LS [lung sounds] slightly exp.			

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	[expiratory] wheezes - productive cough with green sputum - MD notified. Res. req. [requested] Pro-air [an inhaler] at 1:45 p.m. for wheezing, + effective, +2 pit. [pitting] edema to BUE [bilateral upper extremities], bruising noted to BUE...." "02-19-12 at 2315 [11:15 p.m.] [BP] 116/67, P 102, T 97.8, O2 93% room air, RR 20. Pt. has c/o SOB also wheezing present at this time. Inspiratroy / expiratory, lung sounds diminished throughout. Will treat with Duoneb [inhaler]. Pt. has c/o pain in shoulder. Educated pt. on importance of turning deep breathing and coughing to prevent atelectasis/pneumonia. Abd. distended and BLE [bilateral lower extremities] pitting edema 3+ - heels elevated d/t [due to] severe abdominal distension putting pressure on diaphragm and lungs. Keeping HOB [head of bed] elevated > [greater than] 30 degrees."			

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"02-20-12 [day shift] BP 115/61, [P] 95, O2 92 % - room air, [respirations] 20. [Arrow pointing upward] 3.4 # [pounds] - called Dr. [Doctor] to report [arrow pointing upward] wt. gain - Dr. wants res. [resident] sent to [name of local area hospital] ER [emergency room] for eval. [evaluation]."

From the time the nurse assessed the resident at 11:15 p.m., the physician was not notified of the resident's condition for approximately 6 1/2 hours later, when the day shift nurse weighed the resident and discovered the resident with a 3.4 pound weight gain.

2a. The record for Resident "E" was reviewed on 03-23-12 at 12:20 p.m. Diagnoses included, but were not limited to, open reduction and internal fixation due to fracture, cerebral vascular accident with left sided residual, and constipation. These diagnoses remained current

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	at the time of the record review. Review of the resident's current plan of care, dated 02-28-12 indicated "Problem - at risk for constipation due to impaired mobility." "Approach - approach start date 01-01-12 - administer medications as ordered." A review of the January 2012 medication administration record had a physician order for Senna [a laxative] one by mouth every day. The record had the dates of January 11th and 12th [2012] circled. The reverse side of the record lacked information related to the reason the dates were circled. Review of the February 2012 medication administration record contained a physician order, dated 01-01-12 for Cholestyram 4 Gr. [grams] pow. [powder] - a packet by mouth twice daily before meals. The medication administration record had the dates February 28th and 29th [2012] circled. The			

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	reverse side of the record indicated the medication was "unavailable" February 28 the 29th and the pharmacy had been notified. 2b. Review of the pre-admission assessment, dated 12-29-11 indicated the resident "had slipped and fell off a stool and layed on <sic> + femoral fx. [fracture] - neck fx. right hip. Pleasantly confused. Bed alarm for safety." The resident had a physician order, dated 01-01-12 which instructed the nursing staff "bed alarm to bed at all times. WC [wheelchair] alarm to chair at all times." Review of the Minimum Data Set assessment, dated 01-08-12, indicated the resident had moderate cognitive impairment and required extensive assistance with transfer and bed mobility. In addition, the assessment indicated the resident had a bed and WC alarm in place. The nurses notes, dated 02-09-12 at			

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ROSEGATE VILLAGE	7510 ROSEGATE DR INDIANAPOLIS, IN 46237

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	3:30 p.m. indicated the resident was found on the floor per CNA [certified nurses aide]. N.O. [new order] for bed alarms for safety. MD [Medical Doctor] notified." A review of the "Fall Circumstance Report," dated 02-09 [2012] indicated the resident was "sitting on floor - clothes on top none on bottom - unwitnessed, and incontinent at the time of the fall." The "report" prompts "what intervention (s) was put in to place to prevent another fall?" The handwritten notation indicated, "Bed alarm to bed at all times." A subsequent physician order dated 02-29-12 indicated "Clarification - bed alarm to bed at all times, check placement/function qs [every shift]. WC alarm to w/c at all times, check placement/function qs." Review of the resident's plan of care indicated "Problem start date 02-28-12 - resident is at risk for falls due to hx. of falls, fractured			

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	right hip, impaired mobility, weakness, confusion, cognitive impairment, antidepressant, incont. [incontinent] bowel and bladder, pain and requires assist with ADLs [activity's of daily living] and transfers." "Approach - approach start date 01-01-12 Bed alarm, chair alarm." This Federal tag relates to complaint IN00104048. 3.1-35(g)(2)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to provide and ensure a resident received the highest practicable physical care, in that when a resident had breathing difficulties and displayed increased edema, the nursing staff failed to act immediately and inform the resident's physician of a decline in the resident's condition which included increased shortness of breath, increased pitting edema, pain and requiring hospital treatment, for 1 of 3 residents reviewed a sample of 6. [Resident "B"]. Findings include: The record for Resident "B" was reviewed on 03-15-12 at 11:30 a.m.	F0309	F- 309-Provide Care/Services for Highest Well Being **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident “B” was discharged from the facility on 2/20/12. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents having changes in condition have been identified. Physician(s) have been notified and residents have been placed on “hot charting” until condition(s) are stable and/or resolved. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Charge nurse who identifies the change in condition will contact the resident’s	04/16/2012

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	Diagnoses included, but were not limited to, acute renal failure, peritonitis, hematuria, asthma, cirrhosis and hepatic encephalopathy. These diagnoses remained current at the time of the record review. The record indicated the resident had recently been discharged from a local area hospital on 12-05-11 and returned to the facility with instructions for the nursing staff to "Contact information: MD for worsening ascites, abdominal pain, confusion or temperature of > [greater] 100.5." In addition, the resident had a physician order for "daily weight, if at or about 5 lbs. [pounds] in 1 week or 3 lbs. in 24 hours call [name of physician]." Review of the resident's current plan of care dated 02-02-12, indicated "Problem cirrhosis." "Approach - approach start date 12-13-11, observe for altered mental status, increased pain, abdominal distention and		physician to communicate the change. · Charge nurse will document nursing actions/interventions in the nurse's notes and will add the resident to the "Hot Charting" list. · Charge nurse will document change of condition 7 days a week and every shift and call MD for acute change of conditions. · Nurse Managers will review residents daily with change of condition to ensure documentation and intervention has been addressed and physician has been notified. · Nursing staff will be in-serviced by Director of Nursing and/or designee on April 3, 4, & 5, 2012 on change of conditions and physician notification. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized to monitor compliance with reporting changes of condition by the Director of Nursing and/or designee. Nurse's notes observations will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance achieved. · Results of these evaluation processes will be presented to the CQI Committee monthly to	

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	discomfort, n/v [nausea/vomiting], increased weakness/debility, decreased appetite." A subsequent plan of care dated 02-02-12, indicated "Acute renal failure." "Approach - approach start date 12-13-11, observe for s/s [signs and symptoms] of SOB [shortness of breath], increased edema, pain or elevated B/P [blood pressure], refer to MD [Medical Doctor] as needed." An addition plan of care dated 02-02-12, indicated "Resident is at risk for fluid imbalance related to diuretics and fluid restriction." "Approach - approach start date 12-05-11 - observe for s/s of dehydration/fluid overload: dry pale mucous membranes, skin tenting, decreased urinary output, SOB [shortness of breath], dyspnea, increased edema, lethargy, increased wts. [weights], increased abdominal girth." Review of the nurses notes		review for compliance and follow-up. Identified noncompliance may result in action plans, staff re-education and/or disciplinary action.	

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	indicated the following: "02-17-12 at 2245 [10:45 p.m.] HR [heart rate 92, oxygen saturation 93% on room air, [blood pressure] 138/70, T [temperature] 98.2, RR [respiratory rate] 18. No needs currently, no c/o [complaints of] pain, minor SOB [shortness of breath], no dyspnea [difficulty in breathing]. Pt. [patient] does not desire any intervention at this time, occasional NP [non productive] cough, lungs - [arrow pointing downward] volume with crackles in bases and rhonchi present bil. [bilateral] expiratory wheezing present. BS [bowel sounds] positive times 4, abdomen does appear slightly distended, but soft. Pt. states had BM yesterday evening (02-16). Pulses equal / reg. [regular] BUE [bilateral upper extremities]." "02-18-12 at 0100 [1:00 a.m.] [B/P] 127/76, P 108, oxygen saturation 90 % on room air, RR 20, T 96.7. Pt c/o SOB, lungs are			

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	diminished all lobes with inspiratory / expiratory wheezing present. Pt. c/o pain in back also (5/10). Intervention inhaler 2 puffs, neb. [nebulizer] tx. [treatment] and pain tx. with prn [as needed] Tramadol [a pain medication]. Pre treatment O2 [oxygen 90%, shallow breathing, post intervention [arrow pointing downward] wheezing, deep breathing and O2 98 %. Pt. A & O [alert and oriented] times three. pedal pulses palpable bil. [bilateral] with 3 + pitting edema BLE [bilateral lower extremities]. Pt. tachacardic <sic> with minor murmur present." "02-19-12 at 2:00 p.m. - ... Abd. [abdomen] firm / dist. [distended] LS [lung sounds] slightly exp. [expiratory] wheezes - productive cough with green sputum - MD notified. Res. req. [requested] Pro-air [an inhaler] at 1:45 p.m. for wheezing, + effective, +2 pit. [pitting] edema to BUE [bilateral upper extremities], bruising noted to BUE...."			

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	"02-19-12 at 2315 [11:15 p.m.] [BP] 116/67, P 102, T 97.8, O2 93% room air, RR 20. Pt. has c/o SOB also wheezing present at this time. Inspiratroy / expiratory, lung sounds diminished throughout. Will treat with Duoneb [inhaler]. Pt. has c/o pain in shoulder. Educated pt. on importance of turning deep breathing and coughing to prevent atelectasis/pneumonia. Abd. distended and BLE [bilateral lower extremities] pitting edema 3+ - heels elevated d/t [due to] severe abdominal distension putting pressure on diaphragm and lungs. Keeping HOB [head of bed] elevated > [greater than] 30 degrees." "02-20-12 [day shift] BP 115/61, [P] 95, O2 92 % - room air, [respirations] 20. [Arrow pointing upward] 3.4 # [pounds] - called Dr. [Doctor] to report [arrow pointing upward] wt. gain - Dr. wants res. [resident] sent to [name of local			

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	area hospital] ER [emergency room] for eval. [evaluation]." From the time the nurse assessed the resident at 11:15 p.m., the physician was not notified of the resident's condition for approximately 6 1/2 hours later, when the day shift nurse weighed the resident and discovered the resident with a 3.4 pound weight gain. Review of the facility policy on 03-23-12 at 10:00 a.m., titled "Resident Change of Condition," and dated as "revised 3/10, indicated the following: "POLICY [bold type] It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely and effective intervention occurs." "PROCEDURE - 2. Acute Medical Change			

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	a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician." This Federal tag relates to IN00104048. 3.1-37(a)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure supervision and assistive devices were provided for cognitively impaired residents to alert the nursing staff of unassisted ambulation/transfer, in that when a resident had a history of falls, and was identified prior to admission to the facility as a fall risk, the nursing staff failed to provide assistive devices to alert the nursing staff of unassisted ambulation/transfers for 2 of 2 residents reviewed for falls in a sample of 6. [Resident "E" and "D"]. Findings include: 1. The record for Resident "E" was reviewed on 03-23-12 at 12:20 p.m. Diagnoses included, but were not limited to, open reduction and	F0323	F- 323 – Free of Accident Hazards/Supervision/Devices **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident “E” was discharged from the facility 3/18/12. · Resident “D” was immediately assessed and identified to be high-risk for falls. Tag alarm was placed per physician order and her fall risk care plan was updated with new individualized interventions. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents have the potential to be affected. · Fall risk assessments for all cognitively impaired residents have been updated to reflect current accurate resident information. · Care plans for cognitively impaired residents identified as fall risk have been reviewed to	04/16/2012

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	internal fixation due to fracture, cerebral vascular accident with left sided residual, and constipation. These diagnoses remained current at the time of the record review. Review of the pre-admission assessment, dated 12-29-11, indicated the resident "had slipped and fell off a stool and layed on <sic> + femoral fx. [fracture] - neck fx. right hip. Pleasantly confused. Bed alarm for safety." The resident had a physician order, dated 01-01-12, which instructed the nursing staff "bed alarm to bed at all times. WC [wheelchair] alarm to chair at all times." Review of the Minimum Data Set assessment, dated 01-08-12 indicated the resident had moderate cognitive impairment and required extensive assistance with transfer and bed mobility. In addition, the assessment indicated the resident had a bed and WC alarm in place.		ensure appropriate interventions are in place. · All residents with Physician ordered personal alarms have been identified. Resident's beds and wheelchairs have been audited to ensure alarms are in place according to Physician orders. The Plan of Care and Care tracker has been updated accordingly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents who are new admissions/readmissions and identified as being cognitively impaired and high-risk for falls will have prevention interventions initiated per individualized care plan and Physician orders. · Licensed nurses will conduct rounds daily on all shifts, on residents with care plan interventions for personal alarms to ensure interventions are in place and functioning. · All falls will be discussed and fall circumstance report reviewed by the Interdisciplinary team the next business day to discuss other possible interventions to prevent future falls. Care plan and Care tracker will be reviewed and updated as needed. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	

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	Review of the resident's plan of care indicated "Problem start date 02-28-12 - resident is at risk for fall due to hx. of falls, fractured right hip, impaired mobility, weakness, confusion, cognitive impairment, antidepressant, incont. [incontinent] bowel and bladder, pain and requires assist with ADLs [activity's of daily living] and transfers." "Approach - approach start date 01-01-12 Bed alarm, chair alarm." The nurses notes, dated 02-09-12 at 3:30 p.m., indicated the resident was found on the floor per CNA [certified nurses aide]. N.O. [new order] for bed alarms for safety. MD [Medical Doctor] notified." A review of the "Fall Circumstance Report," dated 02-09 [2012], indicated the resident was "sitting on floor - clothes on top none on bottom - unwitnessed, and incontinent at the time of the fall." The "report" prompts "what intervention (s) was put in to place		**program will be put into place?** · A CQI audit tool will be utilized to monitor compliance with prevention interventions of residents at risk for falls by the Director of Nursing and/or designee. Resident observations will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance is achieved. · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance of residents with personal alarms. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance is achieved. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in development of action plans, staff re-education and/or disciplinary action.	

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	to prevent another fall?" The handwritten notation indicated, "Bed alarm to bed at all times." A subsequent physician order dated 02-29-12, indicated "Clarification - bed alarm to bed at all times, check placement/function qs [every shift]. WC alarm to w/c at all times, check placement/function qs [every shift]." 2. The record for Resident "D" was reviewed on 03-23-12 at 9:30 a.m. Diagnoses included, but were not limited to, hypertension, severe malnutrition, congestive heart failure, congestive heart failure and depression. These diagnoses remained current at the time of the record review. Review of the pre-admission "Resident Assessment," dated 03-05 [2012] indicated the resident had "confusion at times, and bed alarm for safety." The resident's Minimum Data Set			

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	Assessment, dated 03-16-12, indicated the resident had severe cognitive impairment and required extensive assistance with transfer, bed mobility and toileting. Review of the "fall risk assessment," dated 03-09-12, indicated the resident was "confused and/or disoriented," and prompted the nursing staff to "proceed to care plan with appropriate interventions based on risk factors." The resident's current plan of care indicated "Problem start date 03-09-12 - Fall risk related to weakness/severe deconditioning, incontinence, confusion, cognitive impairment, receives antidepressants, g [gastrostomy] tube feeding- continuous, pain and requires assist for ADLs and transfers." "Approach - approach start date 03-11-12 bed alarm on at all times to alert staff of unassisted transfers."			

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The resident had a physician order dated 03-11-12, for "bed alarm on at all times. Check every shift positioning and function."

During observation on 03-23-12 at 11:00 a.m., a person who identified self as a "friend" to the resident was seated in a chair adjacent to the resident's bed and waving towards the doorway. When requested to enter the "friend" indicated "yes, come look at [resident], [resident] keeps trying to get up and I'm afraid to leave and [resident] might fall. [Resident] keeps getting up and I tell [resident] to sit back down." During this observation the resident was seated in a wheelchair with the bedside table in front of [resident]. The resident attempted to stand, but with encouragement from "friend" sat back down in the wheelchair.
A licensed nurse was immediately notified. However, the nursing staff failed to assess the resident for safety while seated in a wheelchair,

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	and provide an assistive device to alert the nursing staff of unassisted ambulation/transfer. 3.1-45(a)(2)			

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	155757	A. BUILDING 00 B. WING	03/26/2012

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F0425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to provide medications, in that when a physician ordered medications for a resident, the facility failed to ensure the medication was provided from the pharmacy and administered to the resident, for 4 of 5 residents reviewed for medications in a sample of 6. [Residents "B", "E", "D", and "F"]. Findings include:	F0425	F- 425-Pharmaceutical SVC-Accurate Procedures, RPH **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident “D” medication administration record was immediately assessed for medications that were withheld with no negative outcomes noted. · Resident “B,” was discharged from facility on 2/20, 2012. · Resident “E,” was discharged from facility on 3/18, 2012.	04/16/2012

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	1. The record for Resident "B" was reviewed on 03-15-12 at 11:30 a.m. Diagnoses included, but were not limited to, acute renal failure, peritonitis, hematuria, asthma, cirrhosis and hepatic encephalopathy. These diagnoses remained current at the time of the record review. Review of the resident's current plan of care dated 02-02-12, indicated "problem - asthma." "Approach - approach start date 12-13-11 - administer meds [medications] as ordered." A review of the resident's physician rewrite for February 2012 included an order, dated 12-05-11 for Advair diskus [a bronchodilator] 250/50 - inhale 1 puff every twelve hours. The inhaler was scheduled to be administered at 9:00 a.m. and 9:00 p.m. Review of the February 2012 medication administration record		· Resident “F” was discharged from facility on 1/21/2012. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents’ medication administration records have been reviewed for medications that have been withheld. Reasons for withholding the medication have been documented in the nurse’s notes and/or the back of MAR. · Residents identified as having medications withheld due to medication unavailable, have had pharmacy notified and medications have been sent per physician orders. · All residents with request to hold medications per resident/family request have been identified. Physicians have been notified and nursing actions/interventions have been documented in the medical record. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Residents requiring regularly scheduled medications to be withheld will have the front of the medication record for that dose initialed and circled, and an explanatory note entered in the nursing notes and/or the back of the medication administration	

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	indicated the resident did not receive the inhaler as prescribed at 9:00 a.m. and 9:00 p.m. and February 13th and 14th and again at 9:00 a.m. on February 15th. The reverse side of the medication administration record indicated the following: "02-13-12 advair 250/50 unavailable - phar. [pharmacy] notified." "02-13 advair 250/50 unavailable - phar. notified." "02-14 advair 250/50 unavailable." "02-15 advair 250/50 unavailable - phar. notified said sent on 01-23-12 - found bottom drawer at 1:30 p.m." In addition, the resident physician orders for Rifaxmin [a medication for diarrhea] two times a day at 9:00 a.m. and 5:00 p.m. A review of the medication administration record for December 2012, indicated dates as "circled" on the medication administration record. These dates included December 14, 15, 16, 17, 18 and 19 [2011].		record. · An in-service will be completed by the Director of Nursing and/or designee on April 3, 4 & 5, 2012 to licensed nurses on medication administration. · The Director of Nursing Services and/or designee will assign a licensed nurse to review the medication and treatment administration records daily to ensure medications have been administered per physician orders. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with medication administration. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance is achieved. · Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in development of action plans, staff re-education and/or disciplinary action.	

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	During interview on 03-23-12 during the exit conference at 3:00 p.m., the Director of Nurses indicated if the date is "circled" there had to be a reason the medication wasn't given. "The nurses are suppose to document on the reverse side of the MAR [medication administration record] the reason." Further review of the MAR [2011] as well as the nurses notes lacked information in regard to the reason the dates were "circled" for the medication. The resident also had a physician order, dated 12-05-11, for Xifaxam [an antibiotic] 550 mg [milligram] 1 tablet by mouth twice daily. This medication was scheduled at 9:00 a.m. and 5:00 p.m. The January 2012 medication administration record had dates circled on January 5 - 9:00 a.m. and 5:00 p.m. and January 6th at 9:00 a.m. The reverse side of the medication			

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	administration record lacked documentation related to the reason the dates were circled. Further interview with the Director of Nurses on 03-23-12 at 11:00 a.m. indicated "if the medications were not available, the nurses need to let the pharmacy know the medication is needed 'STAT' they'll deliver them right away." 2. The record for Resident "E" was reviewed on 03-23-12 at 12:20 p.m. Diagnoses included, but were not limited to, open reduction and internal fixation due to fracture, cerebral vascular accident with left sided residual, and constipation. These diagnoses remained current at the time of the record review. Review of the resident's current plan of care, dated 02-28-12, indicated "Problem - at risk for constipation due to impaired mobility." "Approach - approach start date 01-01-12 - administer medications as ordered."			

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	A review of the January 2012 medication administration record had a physician order for Senna [a laxative] one by mouth every day. The record had the dates of January 11th and 12th [2012] circled. The reverse side of the record lacked information related to the reason the dates were circled. Review of the February 2012 medication administration record contained a physician order, dated 01-01-12 for Cholestyram 4 Gr. [grams] pow. [powder] - a packet by mouth twice daily before meals. The medication administration record had the dates February 28th and 29th [2012] circled. The reverse side of the record indicated the medication was "unavailable" February 28 the 29th [2012] and the pharmacy had been notified. 3. The record for Resident "D" was reviewed on 03-23-12 at 9:30 a.m. Diagnoses included, but were not limited to, hypertension, severe			

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	malnutrition, congestive heart failure, congestive heart failure and depression. In addition the admission information from the local area hospital indicated the resident had a history of breast cancer with a left mastectomy and on "chronic Arimidex [a nonsteroidal medication]." These diagnoses remained current at the time of the record review. Review of the medication administration record for March 2012 indicated the medication Arimidex was scheduled to be given to the resident every day at 9:00 a.m. The record indicated the medication had been given as prescribed until it was discontinued on 03-19-12. During an interview on 03-15-12 at 11:00 a.m., the resident's spouse indicated the resident had been on the medication "for years" and now not receiving it. During interview on 03-23-12 at			

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	11:45 a.m., the Director of Nurses indicated the medication had been delivered to the facility - "14 tablets and there were 8 tablets left to send back to the pharmacy." The Medication Administration Record indicated/initialed as dispensed on March 10, 11, 12, 13, 14, 15, 16, 17, 18 and 19th [2012], for a total of 10 doses. During clarification at the daily exit conference on 03-23-12 at 3:00 p.m., if 10 doses were administered, there should only be 4 doses left to be returned to the pharmacy. On 03-26-12 at 9:00 a.m., the Director of Nurses indicated she spoke with the nurse, who obtained the order to discontinue the medication, and she had indicated to the Director of Nurses that the resident's spouse did not want the resident to have the medication, as the resident had not been on it prior to hospitalization. The Director of Nurses indicated the nurse called the oncologist and left a message regarding the family request. The			

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	nurse indicated she had not given any of the medication, but didn't pass on the information to the weekend shift licensed nursing staff and the resident received the medication over the weekend of 03-17-12 and 03-18-12. The licensed nurse signed the medication as given to the resident, and the total to be sent back to the pharmacy was inaccurate. 4. The record for Resident "F" was reviewed on 03-23-12 at 11:30 a.m. Diagnoses included, but were not limited to, inflammatory colitis, dementia, dementia with behaviors and depression. These diagnoses remained current at the time of the record review. The resident had a physician order dated 11-30-11, for Comforte supplement 2 tablets by mouth once daily. Review of the December 2011 medication administration record indicated "circled dates" to include			

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	December 22, 23, 24 ,25, 26 and 27, 2011. The reverse side of the medication administration record indicated the supplement was "not available" on 12-22-11 and 12-25-11 and that the Pharmacy had been contacted. The record lacked documentation related to the other "circled dates." 5. Review of the facility policy on 03-23-12 at 8:45 a.m., and titled "Medication Administration Guidelines," dated as revised 7/2011 indicated the following: "PURPOSE [bold type] To ensure that the right resident gets the right medication at the right time in the right dosage, via the right route. To ensure medications are dispensed in a sanitary manner and to comply with State and Federal Guidelines for administration of medications." "PROCEDURE: MEDICATION PASS [bold type]: If a dose of regularly scheduled medication is withheld or refused by the resident,			

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	the nurse will initial and circle the front of the medication record in the space provided for that dose and, an explanatory note must be entered in the nursing notes and/or in the PRN [as needed] nurses notes section of the medication administration record." "Unless medication is ordered as an emergency or specified as a stat medication by the physician, all orders are presumed to be administered on the first scheduled medication time following their arrival at the facility through the normal delivery process." "NOTE: Any deviation from specified and recommended procedures in dispensing or administering medications to the resident requires documented approval by the Quality Assurance Committee and shall be in concurrence with current statutes and regulations." This Federal tag relates to			

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	complaint IN00104048. 3.1-25(a)			